

Committee on Children Public Testimony

Raised Bill# 1006 – AAC Voluntary Services within the Dept. of Children and Families

Raised Bill #1007 – AAC Permanency Placement

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Thank you for the opportunity to submit testimony on these raised bills.

I am a married parent with three adopted children. Despite varied adoption scenarios (*Son: Domestic, private placement, at birth; Daughters: Kinship/ system facilitated following murder of birth mother in their presence. They were 13-months old and 3-years old at time of trauma/ loss.*), all my children have attachment disruption-rooted challenges. Both of my girls suffer from PTSD. My youngest daughter, who was non-verbal at the time of this trauma, suffers from several mental, emotional, behavioral conditions that present in a variety of troubling, sometimes disturbing, and unstable ways. Her symptoms cycle seasonally. She is socially reactionary. She has difficulty regulating and is triggered by many unpredictable environmental, social, emotional, psychological and neurological factors that can render her unsafe to herself or others; and she is medicated to help maintain her behaviors. Her symptoms have been so significant that she was acutely hospitalized twice before the age of 8. She is also a beautiful, creative, smart child.

My experience with pursuing Voluntary Services as a means of accessing appropriate, condition informed, clinician recommended models of care and services for my daughter, and supports for our family, was anguishing, traumatizing and highly counter-productive. We were denied access to voluntary services (said to be due to budget cuts), threatened, humiliated, lied to, and then accused of parental wrong doing. The case against us was incomprehensible and costly on many levels. (*Among other claims, I was accused of emotional neglect/ abuse and that I mislead independent psychiatric providers because I didn't want or love, nor could I bond with, our troubled daughter.*)

At the hands of DCF, we were not supported or viewed as credible. Our family strengths were omitted from case documentation or minimized; subjective weaknesses exploited. We were viewed through a

‘protective’ lens, and processed in that image. Our daughter was needlessly removed from our care for a period of 2-years, (4-foster placements) received little informed treatment during that time, was re-traumatized and her attachment disruption conditions were compounded. The permanency plan included adoption of our daughter to another family. Termination of parental rights was threatened and actively pursued by the Department. Court Ordered, DCF designed specific steps were protective based and excessive, setting us up to fail. Our daughter’s best interest was moot.

Child psychiatric conditions are easily misunderstood and resulting family dynamics, often misinterpreted. Although Public Act 13-178, the Sandy Hook Advisory Board and CONNECT Grant driven efforts are leading to a redesign of the State’s child behavioral health delivery system of care; the training and skill level of DCF social workers and investigators remains questionable. System reform takes time. Attitude and practices don’t change overnight. Funding strategies to implement such reforms often lag behind.

Language in these Bills has the potential to adversely impact on families like mine. Federal funding programs, driving tighter case timeframes and altered caregiver qualification helps DCF to gain custody of a child, terminate parental rights and expedite the process of adopt a child out of the system more quickly. These bills suggest expediting these matters is priority, but at what price to family preservation and child best interest?

- Bill# 1007 – (k) (1) (A) line 7...”Any party seeking to oppose the commissioner’s permanency plan, including a relative of a child or youth by blood or marriage who has intervened pursuant to subsection (d)” ... **should not be required to be a licensed foster parent.** The word “**and**” concerns me.
- Bill# 1007 - Permanency placement planning, for any child with a diagnosed or diagnosable mental, behavioral or emotional condition(s) or disturbance or history of adverse childhood experiences (ACE) such as but not limited to, loss of a parent, psychiatric hospitalizations, extended psychotherapy, complex trauma exposure while in the care of a previous caregiver must include maintaining current caregiver connections, visitation and involvement in an permanent manner; unless the individual caregiver is convicted through an evidentiary-based process as criminally guilty of a child abuse/ neglect offense.

- Bill #1006 - Any voluntary admission to voluntary services, including out-of-home admission or placement, should not require the State to obtain full and sole custody of a minor child. In addition to included language, as to DCF not being permitted to use investigation content against the parents, DCF should not be permitted to seek, through the use of subjective parent ‘concerns’ as fact, harassment or coercion, Court Order or otherwise, full or sole custody of a child for the purpose of accessing therapeutic out-of-home admission or placement of any kind. In these matters, custody of the child should be deemed and facilitated as joint, shared equally by the State’s DCF and the parents. *(The state of Illinois recently passed legislation of this kind (HB 5598). Their new law preserves the State’s ability to draw down Title VI funding for children in their care and provides for full engagement of competent, nurturing parents/ caregivers to maintain their parenting roll and relationship with their child, maintain full participation in the therapeutic process, unencumbered visitation and equitable participation in medical/ mental health treatment planning and decision making of the child.) See an Issue Brief² describing the issue and family experiences with links including one to IL Bill #5598.*

The DCF should be **required** to work in concert with these families, as part of a strength-based team model, in the child’s care and permanency planning. The Department should not move more quickly to terminate contact or parental rights in such matters. Each case, involving a child, especially those with a psychiatric condition(s) feature, are not sprints, they are marathons as competent, timely and informed care arrangements can take time to engage and benefit from. It is also in the best interest of a child to ensure that all material case content is factual and evidentiary, which is not currently required; and that the child *feels* loved, connected and part of their committed family unit throughout the intervention and healing process.

CUSTODIAL/ PARENT RIGHTS RELINQUISHMENT - ISSUE BRIEF

Connecticut's practice of parental rights relinquishment as a means of access to intensive child mental health care is routine

Issue introduction

Despite CT law to suggest prevention measures are in place, parental rights relinquishment of moderate to severely, psychologically impaired children, for the purpose of accessing intensive, out-of-home care i.e. residential psychiatric admission, therapeutic group, foster and safe home placement or other forms of out-of-

home therapeutic placement, is common place. Connecticut's DCF, through its child protection lens, maintains policies and practices to encourage parents to 'give up on', 'walk away from' and abandoned their struggling, unstable, often unsafe children. Both voluntary (coerced) and involuntary (Court ordered) relinquishments occur as part of standard practice in cases where parents are left few options and look to DCF for funding and support to access an array of therapeutic options.

As a result, family and child are most often permanently separated. All family members are traumatized. The impaired child is no longer part of a forever family. Long term grief, loss and anguish prevails. Parents are labeled and remain on the State's neglect/abusive registry; and costs of 'appropriate' care and treatment are diffused to federal program reimbursement objectives and criteria.

Family & impaired child experience

Intervention practices are skewed, steering case objectives away from family preservation regardless of the parents' aspirations and abilities to love and raise the child. Embellishment and distortion of the family perspectives and dynamics are documented to portray an ill-placed caregiver mindset. Threatening investigation/ assessment tactics, fact twisting, case plan narrative exaggeration and interrogation-like questioning of those easily swayed is used to give life to empty suspicions; and word tailoring is applied to strongly suggest 'concern' over a parent's ability to nurture, care for, cope with and keep safe the impaired child. Deliberate omission of facts showing parents in positive, capable, informed light is also common place.

Juvenile and dependency court systems and their 'status quo' flow of cases is maintained with little regard for individual case particulars or child condition diagnosis. Psychiatric provider recommendations are downplayed and often over ruled by unskilled DCF case and supervisor workers. Judges are limited in their judicial scope to interpret the true facts as they pertain to the court provided narrative, as early presentation of the fact by parents is not encouraged or supported; and often Judges appear to exercise a 'hands tied' ruling – void of clear, unencumbered understanding or facts, household experience, first hand third-party provider commentary or child capability.

This course perpetuates relinquishment agreements, rulings and adverse outcomes.

Cause & scope

There is a financial incentive for states to place children in foster care in order to pay for residential care. As a state ward, a child allows the child welfare agency to draw down Title IV E funds. When parents remain guardians of the same child, the child is not eligible for those same funds.

It's the same child, the same needs, but the parent cannot access the Title IV E funding for that child, unless they take the Devil's Deal and trade custody for treatment.

This is a tragedy for adoptive children who end up back in the system as "second time foster children" because they were neglected and traumatized as first time foster children. As such, they are best served with trauma and attachment therapies. When attorneys, caseworkers, judges, GAL's and others act "en loco parentis" (in lieu of parents), the trauma/attachment therapy is less effective as the child gets confused as to who his parents are and to whom he should be bonding too.

Federal monies are being spent in the child protection system (child welfare plus juvenile courts) with the state as guardian rather than being spent on the child in a clinical serving system with parents as guardians. Money should follow the child rather than the system he's in. It's the same child with the same clinical needs with the same parents with the same costs. We need to get the funding into the proper system so that children can access appropriate treatment while retaining full family preservation, just as we would do for any child with a physical illness.

Statute language

Sec. 17a-129. Department not required to seek custody of certain children and youths. There shall be no requirement for the Department of Children and Families to seek custody of any child or youth with mental illness, emotional disturbance, a behavioral disorder or developmental or physical disability if such child is voluntarily placed with the department by a parent or guardian of the child for the purpose of accessing an out-of-home placement or intensive outpatient service, including, but not limited to, residential treatment programs, therapeutic foster care programs and extended day treatment programs, except as permitted pursuant to sections 17a-101g and 46b-129. Commitment to or protective supervision or protection by the department shall not be a condition for receipt of services or benefits delivered or funded by the department.

There is no requirement, but it is preferred. Further, if a parent/ caregiver is "suspected" of neglect/abuse (No evidence of any kind is required.), the Department may pursue custody of the impaired child without parent/ guardian consent. Voluntary services, which is the mechanism by which a parent may 'voluntarily place' a child with the Department, is underfunded, lacks an array of service options and is geographically inconsistent.

This statute prohibits the DCF from conditioning the provision of mental health services on either commitment or protective supervision; yet in practice, it looks, feels and acts required and plays out as such in the majority of cases.

Solution: Legislation and amended statute language

IL recently passed legislation to address this same issue. **Shared custody** is at the heart of the solution. Proposing similar legislation in CT would be a start in a healthier, less intrusive and traumatic, and less costly direction.

IL HB 5598 – An Act Concerning the Prevention of Custody Relinquishment

Legislation summary: This bill helps parents retain custody of their child during a time when it is necessary to place the child in an institution on a short-term basis.

SYNOPSIS AS INTRODUCED:

20 ILCS 505/5.40 new 20 ILCS 505/5.41 new

Amends the Children and Family Services Act. Provides that when a child is voluntarily placed in out-of-home care funded by the Department of Children and Family Services for the purpose of obtaining mental health treatment for the child or treatment for the child's developmental disability, the Department is prohibited from requesting, recommending, or requiring that a parent terminate his or her parental rights with respect to the child or that a parent or legal guardian transfer legal custody of the child to the Department. Provides that a child voluntarily placed in out-of-home care shall be placed pursuant to a voluntary placement agreement voluntarily entered into by the parents or legal guardian of the child. Provides that for a child to remain in out-of-home care for longer than 180 days, a juvenile court must make a judicial determination within the first 180 days of the placement that the placement is in the best interests of the child. Requires the Department to report annually to the General Assembly concerning (i) the number of children who were voluntarily placed in out-of-home care funded by the Department and (ii) the number of parents or legal guardians who relinquished custody of their child for the purpose of seeking mental health treatment for the child or treatment for the child's developmental disability. Contains provisions concerning: an interagency agreement between specified State agencies to prevent children from becoming wards of the State and entering the child welfare system solely for purpose of treatment of a child's serious mental illness, serious emotional disturbance, or developmental disability; certain protocols that must be included in the interagency agreement; and additional reporting requirements. Effective immediately.

Fiscal breakdown

Cost associated with this legislation is limited, as the IL Bill, for instance, as proposed and enacted allows for shared custody of the child, which preserves and maintains the flow of federal funding associated with the child being placed in state custody. (It does however ensure unencumbered parent contact and medical/mental health treatment input and direction decision making authority. It ensures parents are viewed and regarded in the process as equal and responsible participants in determining what is best for the child. It preserve dignity and family unity, and reserves judgment to those trained in psychiatric care.)

Additional cost factors may include expenditures associated with administrative, communication, and functionality of care and case management. These additional costs, if any, would likely be incorporated into the CONNECT Grant and PA 13-178 cost parameters as currently being designed by groups and committees associated with both the Grant and the Public Act recommendations.

Cost savings may be realized associated with fewer cases processed as 'protective' matters.

Emphasis data

- According to several family/ DCF matter defense attorneys, many, many Connecticut parents face the choice between treatment and guardianship rights every year. Generally, attorneys receive calls when the child is ready for discharge from the hospital and there aren't any services available, so the discharge plan recommends discharge to home. The parents know they and their other children can't be safe, and are afraid to take the child home. At that point, the hospital staff tells parents that staff will call DCF and DCF will charge the families with neglect/abandonment.
- Since many children are Medicaid eligible, and the EPSDT (Early Periodic Screening, Diagnosis and Treatment) provisions of Medicaid entitle children to any necessary mental health evaluations and treatment, CT's implementation of the Medicaid statute is also in need of review.
- Medicaid dollars only pay room and board charges for "psychiatric residential treatment facilities" (PRTFs), not just "residential treatment" facilities (RTF). The Behavioral Health Partnership, which runs all of this in CT, has level of care guidelines which designate who gets what services when. This overrides any psychiatric provider diagnosis-driven treatment plan or recommended crisis response plan.
- This is all part of managed care. Problems arise again and again when the kids are hospitalized, need PRTF, and CT doesn't offer enough beds. So the kids are discharged to home, where no one in the family is safe.

Family testimony relative to the content of this briefing is available.

The number of DCF filed 'uncared for' cases and neglect/ abuse/ abandonment cases where accused parent/ caregivers plea down to 'uncared for' (due to special needs) is said to be unknown and not tracked.

Links –

http://il.nami.org/HB5598_Prevention%20of%20Custody%20Relinquishment%20Fact%20Sheet_3%2024%2014.pdf

<http://www.hslda.org/cms/?q=bill/house-bill-5598-changes-law-surrounding-state-child-custody>

<http://legiscan.com/IL/bill/HB5598/2013>